JUSTIFICATION OF NEED FOR PROSTHESIS

Complete Dentures - Resin Base Partial Dentures - Cast Metal Framework Partial Dentures

This form is to be completed by the dentist providing treatment. Submit this form with the associated TAR.

PATIENT: _____ **DATE:** _____

ADDRESS BOTH ARCHES -- COMPLETE EACH APPROPRIATE SECTION *(TYPE OR PRINT CLEARLY)*

MAXILLARY ARCH	**MANDIBULAR ARCH**
Appliance Requested: ☐ FUD ☐ Cast Metal PUD ☐ Resin base PUD	Appliance Requested: ☐ FLD ☐ Cast Metal PLD ☐ Resin base PLD
☐ Never had a maxillary prosthetic appliance	☐ Never had a mandibular prosthetic appliance
☐ Has an existing maxillary prosthetic appliance	☐ Has an existing mandibular prosthetic appliance
Existing Appliance: ☐ FUD ☐ Cast Metal PUD ☐ Resin base PUD	Existing Appliance: ☐ FLD ☐ Cast Metal PLD ☐ Resin base PLD
Age of Appliance: _____	Age of Appliance: _____
Wears appliance? ☐ Yes ☐ No	Wears appliance? ☐ Yes ☐ No
If 'No', please explain: _____	If 'No', please explain: _____
Catastrophic Loss? ☐ Yes ☐ No	Catastrophic Loss? ☐ Yes ☐ No
Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of official public service agency report.	Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of official public service agency report.
If lost in facility or hospital, explain circumstances: _____	If lost in facility or hospital, explain circumstances: _____
Reason for replacement of existing maxillary appliance: (Check all boxes that apply)	Reason for replacement of existing mandibular appliance: (Check all boxes that apply)
☐ Worn/Broken teeth ☐ Loose ☐ Broken base / Framework	☐ Worn/Broken teeth ☐ Loose ☐ Broken base / Framework
☐ Extraction of additional teeth ☐ Other _____	☐ Extraction of additional teeth ☐ Other _____

Edentulous ☐ Maxillary ☐ Mandibular

X Block out missing teeth	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
O Circle teeth to be extracted	**32**	**31**	**30**	**29**	**28**	**27**	**26**	**25**	**24**	**23**	**22**	**21**	**20**	**19**	**18**	**17**

REQUIRED FIELD FOR PARTIAL DENTURES (All Types)

MAXILLARY ARCH	**MANDIBULAR ARCH**
Teeth being replaced: _____	Teeth being replaced: _____
Teeth being clasped: _____	Teeth being clasped: _____

ADDITIONAL COMMENTS PERTAINING TO TREATMENT PLAN:

_____

_____

_____

_____

_____

_____

Provider Signature _____

DC054 (Rev 09/18)